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Future Directions in Public Health – Calcutta and Beyond

*Report and Recommendations of an
Informal Consultation
New Delhi, 8-11 December 2003*



World Health Organization
Regional Office for South-East Asia
New Delhi
February 2004

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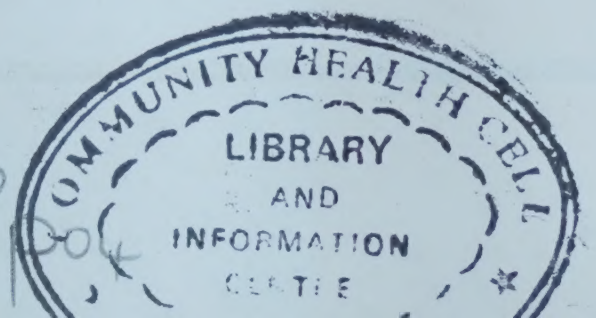
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EXECUTIVE SUMMARY

Human development primarily aims at enlarging people's choices, including the freedom to choose a healthy lifestyle, and access appropriate health care. Improvements in health are important in their own right; better health is also a prerequisite and a major contributor to economic growth and social cohesion. Health systems should be reinforced based on the core principles of primary health care as outlined at Alma-Ata in 1978 and reinterpreted in the light of the dramatic developments over the past 25 years. The road map prepared following the UN's Millennium Summit had established goals and targets to be attained by the countries by 2015. The Millennium Development Goals, in the area of development and poverty eradication, place health at the heart of development, thus providing an opportunity for concerted action to improve global health.

The landmark Calcutta Declaration, adopted in 1999 at the Regional Conference on Public Health in South-East Asia in the 21st Century, had urged the promotion of public health as a discipline and an essential requirement for health development, and outlined important recommendations for strategy and direction. An Informal Consultation on 'Future Directions in Public Health – Calcutta and Beyond' organized by WHO in New Delhi from 8 to 11 December 2003 assessed the progress, and charted the way forward. Thirteen participants, assisted by advisors, also deliberated on the measures to operationalize networking of Public Health Institutions (PHIs) in the Region. The Regional Director-nominee, Dr Samlee Plianbangchang, was a Special Invitee.

Dr Uton M. Rafei, Regional Director, WHO, SEARO, in his inaugural address, detailed the significant work undertaken by WHO in pursuance of the strategic directions in the Calcutta Declaration. Public health is increasingly recognized as a discipline and an essential requirement in all countries in the Region. Accreditation guidelines had been developed for Public Health Education and Training Institutions. Guidelines and a plan of action were formulated for networking of PHIs. An international executive programme in public health was organized, when the idea to establish a regional MPH programme evolved. Core curricula in family medicine were developed, and specific mechanisms recommended for promoting family medicine programmes, which bridge public health with clinical medicine.

Some countries had adopted/adapted the regional accreditation guidelines, while others were promoting development of guidelines and standards for public health education. The Mahidol University in Thailand, which was identified as the lead institution for the networking, had made plans to advance regional networking of PHIs with a meeting in the first half of 2004. A regional web-page was being developed.

Career development in public health, with cadre restructuring and development of career paths, would be crucial to make the public health profession attractive, enhance the image of the organization, and increase commitment, motivation and performance. Public health education should be a component of training and orientation programmes for all health professionals. Talented people should be identified and attracted/encouraged to take up careers in public health discipline with opportunities for super-specializations, Dr Uton added.

Public health teachers perform only limited public health practice, and public health practitioners have limited involvement in academic activities. Redefining public health's role in evolving systems calls for radical reforms in the education of both providers of individual care and practitioners of population-based medicine. A Public Health Council could be established at par with other professional councils.

New and emerging health issues, such as SARS and HIV/AIDS, have underscored the need to redefine, adjust and strengthen public health systems, mainly through a PHC approach. Investments in health workforce should be carefully reviewed to ensure availability of an adequate number, type and distribution of health professionals. Public health practice requires close co-ordination with curative health services for effective and efficient functioning. Multi-sectoral efforts were needed to address the socio-cultural health seeking behaviour of communities, using the 'healthy settings' concept. There is need for high level commitment, sharing of experiences, partnerships, replication of success stories and involvement of the private sector to meet the growing health needs.

Public health research, essential to improve the design of health interventions, policies and service delivery, should receive more importance, respectability, recognition and resources. Research should focus on health determinants, disease epidemiology, health economics, health systems and health policies. Health research systems could contribute to social outcomes such as knowledge, health, human rights and economic growth. PHIs could

play a stewardship role as focal points, prime movers or think-tanks for good governance in health research, and in setting national priorities and agenda for health research.

Towards improving Public Health as a discipline, the consultation recommended instituting a cadre of Public Health professionals at central, state and district levels in the countries, strengthening their leadership and managerial capabilities, capacity building of PH teaching institutions, enhancing their collaboration with national programmes, and organizing regular refresher courses for public health professionals. It advised WHO to establish a SEAR forum on Public Health, identify and mobilize resources for strengthening PH institutes/departments, and perform an advocacy role.

For strengthening the capacity of the PHIs and enhancing PH capabilities through technical cooperation and collaboration in teaching/training, practice and research, the consultation recommended the formation of a South-East Asia Public Health Education Institutes Network (SEAPHEIN) and formulated its draft Terms of Reference. The network should have short, medium and long-term plans and programmes to be implemented through time-bound activities. The suggested activities include information exchange, collaborative multi-centric research projects, joint programmes, pooling of expertise and facilities, technical resource coordination, quality improvement, accreditation and information systems, guidance and support. Partnerships between programmes and between PHIs should also be strengthened at national and regional levels to promote cooperative and collaborative efforts. Greater community involvement should be promoted in public health development activities.

The consultation also suggested a road map for the network through formalizing of networking and membership through a Memorandum of Understanding, and creation of e-networking linkages and local networks. A comprehensive review of capacity and the current status in various PHIs was recommended along with documentation of the best practices relating to PH in the Region, curriculum development and launching of a regional MPH Programme, organizing regional training programmes in public health, faculty development programmes and fellowships in various sub-specialties of public health, and review of existing curricula of health professionals with reference to training in public health. WHO was requested to establish a secretariat at SEARO to be guided by an Advisory Committee, include 'Public Health as a discipline' as an important agenda item in upcoming regional meetings, and

arrange the initial "seed funding" for successful performance of the proposed activities.

The Regional Director-nominee, Dr Samlee Plianbangchang, called for multidisciplinary and multisectoral actions to achieve public health goals, through the development and implementation of public health programmes, such as health education, nutrition, water and sanitation, malaria control, tuberculosis control, prevention of drug addiction and mental health. To strengthen public health in SEAR, he highlighted the need for human resource development. While there were many challenges, the agenda was being systematically set in place, and with the commitment demonstrated by the countries as well as WHO, the next few years would see a resurgence in public health education, services and research in the South-East Asia Region.

In his closing remarks, the Regional Director expressed the hope that networking of PHIs, developing partnerships, and strengthening research programmes in public health would facilitate effective and efficient health systems in the countries of the Region. Some countries like Thailand and Indonesia had made good progress in this direction, and other countries could follow their example.

REPORT

1. BACKGROUND

The discipline of public health has undergone major conceptual changes in recent decades. During this period, the South-East Asia Region witnessed significant challenges and opportunities in public health development. Besides the continuing burden of communicable diseases, the Region faces an increase in noncommunicable diseases. While new diseases are emerging, certain old diseases have also re-emerged. Other challenges include the health consequences of urbanization, ecological imbalances, changing social structures, globalization, decentralization, and providing care for the underprivileged. The rapid containment of SARS in 2003 was one of the biggest success stories in public health in recent years. The prospect of eradication of polio in the next few years exemplifies the value of partnerships in health development.

The health systems in the Member Countries of the South-East Asia Region have to contend with paucity of human resources, paucity of reliable health information, constraints in financial resources, and stewardship challenges of implementing pro-equity health policies in a pluralistic environment. Meeting these formidable public health challenges calls for reinforcement of health systems based on the core principles of primary health care, as outlined at Alma-Ata in 1978. These, however, need to be reinterpreted in the light of the dramatic changes in the health field over the past 25 years.

The Ministers of Health from countries of the South-East Asia Region had, in a Regional Declaration in 1997, urged an urgent review of public health on the basic perception that public health systems were in disarray. WHO took the initiative to organise the Regional Conference on Public Health in South-East Asia in the 21st Century in 1999 at Calcutta. Experts at this conference reviewed the public health scenario extensively and addressed the issues of erosion of public health professional capabilities, declining trends in public health education, newer concepts in public health practice and education, emerging international issues in public health, and increasing the social commitment to public health. The outcome – the landmark Calcutta

Declaration – urged the promotion of public health as a discipline and as an essential requirement for health development in the Region. Several important recommendations pertaining to strategy and direction were also made at this conference.

It was felt that with the passage of four years after the adoption of the Calcutta Declaration, the time was ripe for reviewing the progress made in public health and to chart the way forward. With this in view, WHO organized an informal consultation on 'Future Directions in Public Health – Calcutta and Beyond', at its Regional Office in New Delhi, India, from 8 to 11 December 2003.

1.1 Objectives of the Consultation

The overall objectives of the informal consultation were to:

- (1) Assess the progress in the implementation of the Calcutta Declaration
- (2) Identify constraints and opportunities for improving public health as a discipline
- (3) Define measures to operationalize networking of Public Health Institutions in countries of the South-East Asia Region
- (4) Recommend follow-up action for further promotion of public health in the Region.

1.2 Expected Outcomes

While it was expected that a comprehensive review of the developments since the Calcutta Conference would be made, the main tangible outcomes included:

- (1) A consensus statement on identification of constraints and possible opportunities for improving public health as a discipline
- (2) A draft plan for networking of Public Health Institutions in countries of the South-East Asia Region, including details of structure, functions and the modes of operation
- (3) A road map of activities and measures with identification of responsible agencies with a time frame for further promotion of public health in the Region.

1.3 Methodology of the Consultation

Thirteen participants from Member countries, along with four representatives from leading public health associations and international NGOs active in the Region attended the consultation. A team of 19 advisors and officers from the WHO Regional Office headed by the Regional Director provided technical support. The Regional Director-nominee, Dr Samlee Plianbangchang, also attended as a special invitee.

The consultation utilised a variety of approaches effectively for achieving its objectives. These included plenary sessions, group work, thematic sessions, and a panel discussion. Experts made presentations at the plenary sessions on the progress made since the Calcutta Declaration and the various challenges faced in public health, each followed by intense discussions.

Three thematic sessions, each lasting half a day, were held on the following themes:

- (1) Challenges, opportunities and constraints in improving public health as a discipline;
- (2) Health systems research and its place in strengthening public health, and
- (3) Structure and operationalization of networking of public health institutions in the Region

At each of the thematic sessions, group work followed the presentations and discussions. A panel discussion was also held on the role of public health in disease control programmes, where experts shared their views with participants. In the final working session, participants formulated specific recommendations to the countries as well as to WHO on the next steps to promote and advance public health in the Region.

2. INAUGURAL SESSION

Welcoming the participants, the Regional Director, **Dr Uton M. Rafei**, in his inaugural address referred to the current priorities in public health practice and education and underlined the "Calcutta Declaration" as a landmark in public health development in the Region. He mentioned that the technical units in the Regional Office had undertaken significant work in pursuance of the four elements of the Calcutta Declaration. A regional consultation in 2002 had discussed "Accreditation Guidelines for Public Health Education and Training Institutions" and an Intercountry Meeting in early 2003 had

formulated guidelines and a plan of action for "Networking of Public Health Institutions".

The Regional Director expressed satisfaction at the increased attention given to public health education, training and research in Member countries. Some countries had adopted or adapted the regional guidelines on accreditation. Others were promoting the development of guidelines and standards for public health education. Public health was increasingly being recognized as a discipline and an essential requirement in all countries of the Region, he said.

Reviewing the progress in networking of public health institutions, Dr Uton mentioned the initiatives taken in this regard by Nepal and Thailand. The Mahidol University in Thailand, identified as a nodal point, had plans to advance regional networking in public health, with the first meeting on Networking of Public Health Institutions in the Region scheduled for April 2004. A regional web-page was also under development.

Drawing a distinction between medical education and public health education, Dr Uton said that while the former dealt primarily with institutions and individuals, the latter dealt with the community. Focussing on some challenges to public health today, Dr Uton urged ministries of health in countries of the Region to provide equitable access, remove imbalances in service provision and provide affordable and quality services. Meeting the challenges of epidemiological and demographic transitions required a sufficient number of well-trained public health personnel. Existing epidemiological surveillance systems and the capacity of public health laboratories needed to be strengthened to tackle emerging epidemics and new diseases, such as SARS. A greater demand for public health training needed to be generated, and training institutions needed to review their activities to enhance necessary skills and knowledge across the full array of public health needs.

Dr Uton also drew attention to the increasing need for regulating the expanding private sector to include a public health orientation, and control out-of-pocket expenses for health care for the middle classes and the poor. Strengthening public health infrastructure and developing human resources had also become urgent with the global focus on the 3 by 5 initiative of the Director-General of WHO to contain HIV/AIDS.

Dr Monir Islam, Director, Family and Child Health, WHO/SEARO explained the objectives and expected outcomes of the consultation. Dr P.T. Jayawickramarajah, Coordinator, Strengthening of Health Systems, WHO/SEARO introduced the participants and the secretariat.

Prof V.P. Reddaiah, Professor and Head of the Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi was nominated as Chairperson with **Dr Hanny Prihatni**, Faculty of Medicine, University of Padjadjaran, Bandung, Indonesia, as the Vice-Chairperson. **Prof Indira Chakravarthy**, Dean of the All India Institute of Hygiene and Public Health, Kolkata, India and **Mrs Rossukon Kangvallert**, Health Policy Analyst at the Bureau of Policy and Strategy, Ministry of Public Health, Bangkok, Thailand, were nominated as Rapporteurs.

3. PLENARY SESSION I - DEVELOPMENTS SINCE THE CALCUTTA DECLARATION

Reviewing the progress since the Calcutta Declaration, **Dr Palitha Abeykoon**, WHO Temporary Adviser, outlined the salient developments towards promoting public health as an essential requirement for health development and strengthening the capacity of the public health institutions in the South-East Asia Region. Exciting new challenges and opportunities in public health had arisen due to the rapid advances in health sciences, the changing epidemiological and demographic profiles, consequences of globalization and market mechanisms, changing economic scenarios and the increasing movement of people; these could soon change the face of public health as we know it today.

Commenting on the changes in the health scenario and public health in the past century, Dr Abeykoon categorised the development of public health into four phases: (i) environmental phase; (ii) individualistic phase, (iii) therapeutic phase, and (iv) the phase of New Public Health. The last phase, which began in the mid-1970s with research showing the resultant benefits to health of behaviour modification and environmental change, also recognized the intrinsic connection between health and poverty in individuals, and health and development in nations. It sought to bring health into the development framework and to ensure that health was protected in public policy.

New public health has also been variously described as a renaissance of public health, modern public health and revitalized public health. It encompasses preventive and curative services, adopts a developmental approach to health, with the promotion of stronger health programmes having a greater relevance to various facets of development. Public health, thus, needs to deal with issues that earlier fell outside the traditional concerns of the health sector. Dr Abeykoon drew attention to some challenges facing public health in the Region and underscored the need to respond to these through an integrated public health and medicine approach, involvement of policy-makers, health professionals and managers, and public health institutions and communities.

Recognizing that public health institutions in many SEAR countries were in a state of disarray, the Ministers of Health of the countries in the South-East Asia Region had, in a Regional Declaration in 1997, urged WHO to initiate immediate action. The Regional Conference on 'Public Health in South-East Asia in the 21st Century', that WHO organized in 1999 at Calcutta (Kolkata), India, had extensively reviewed the situation and addressed the issues of erosion of public health professional capabilities, declining trends in public health education, newer concepts in public health practice and education, emerging international issues in public health and increasing the social commitment to public health.

The Calcutta Declaration, adopted at this Conference, urged the promotion of public health as a discipline and as an essential requirement for health development in the Region and advocated recognition of the leadership role of Public Health in formulating and implementing evidence-based healthy public policies and programmes. As part of the strategic approach, the declaration advocated creating appropriate career structures in public health at national, state/provincial and district levels, increasing allocation of resources for all facets of public health, strengthening of education and training in Public Health, and utilizing research as a strategy to support these objectives. The declaration also urged the countries and WHO to collaborate in building partnerships, establishing a strong network of public health institutions, and using information technology in these efforts.

Dr Abeykoon outlined the major developments since the adoption of the Calcutta Declaration. WHO had formulated guidelines for accreditation of public health programmes and educational/training institutions at a Regional Consultation at Chennai, India in early 2002; these were being tested in a few countries.

WHO had organized an International Executive Programme in Public Health in September 2002 as the forerunner to greater cooperation in public health education and training in the Region. Focussing on the theme, “New Perspectives on Global and Local Challenges”, it addressed three emerging subjects – globalization and public health, decentralization and gender-sensitive health services. It was during this period that the idea of establishing a Regional MPH programme evolved.

Dr Abeykoon proposed the following activities as priorities to be undertaken in the next few years for further development of public health:

- (1) ***Promotion of public health as a discipline at the national level*** – with greater support from the political leadership, creation of career paths at various levels, development of strong public health intelligence and disease surveillance systems, and effective programmes to tackle the emerging health challenges. Countries should make their economies work for public health with public health providing leadership for generating evidence-based healthy public policies and enhancing societal responsibility.
- (2) ***Strengthening partnerships between programmes and between Public Health Institutions*** – at national and regional levels to promote cooperative and collaborative efforts to establish an equitable health order; and networking of public health institutions to facilitate capacity building, information exchange and exchange of students and faculty. Mahidol University has taken the lead to organize the first meeting of the network in 2004.
- (3) ***Development of a Regional level MPH and short courses on topical subjects*** – which could centre around the University of Padjadjaran along with plans for staff development and financial arrangement for 5 to 10 years to ensure the programme’s quality and sustainability.
- (4) ***Accreditation of Public Health Institutes and Programmes*** - by developing an inventory of regional resources and formulating mechanisms and instruments towards achieving equivalence, quality and greater uniformity among the different programmes.
- (5) ***Promotion of greater community involvement in public health development activities*** - through intense discussion, collaboration and focussed action and by developing clearer concepts and

different models for testing out the most appropriate mechanisms and modalities.

- (6) **Further development of research in public health** – by developing the researchers' competencies, setting up field laboratories, strengthening management of health research, better dissemination of research findings for evidence-based policy-making etc.
- (7) **Mobilization of resources** to support all of these activities.

In the ensuing discussions, the following points were highlighted.

- Public health professionals should develop special skills and competencies in solving public health emergencies and problems and provide leadership, instead of being guided by persons lacking such special training.
- While there is an urgent need for a regional MPH programme, its curriculum needs careful designing with incorporation of competencies needed for 'new public health', such as leadership skills, managerial skills, communication skills, and social and behavioural sciences. Institutions with experience in conducting such programmes could share this with other institutions.
- Thailand's experience has clearly shown that the WHO Accreditation Guidelines for Educational/Training Institutions and Programmes on Public Health are very beneficial in formulating national standards.
- Public health institutions need to develop partnerships and networking not only among themselves, but also with institutions of allied disciplines, as the public health discipline cannot function in isolation. The networks should also include public health practitioners, service providers, community organizations and local government institutions.
- Public health should change from a stand-alone approach to a well-coordinated multi-professional approach, with support from the local government system. Detailing the development activities in public health in terms of services and human resource development would provide clarity and direction.
- For public health to move in the expected direction in the regional context, resource mobilization has to be country specific.

Dr S.D. Gupta, Director, Institute of Health Management Research, Jaipur, India, in his presentation on “**Career Development in Public Health**”, highlighted the changes that had occurred in the dimensions of public health with the changing health scenario due to epidemiological and demographic transition and changing lifestyles, inequity in access to health care, increasing costs, advances in health technology, the rising expectation of people, and poorly managed health systems. New challenges were being posed by globalization. The UN Millennium Development Goals had set new benchmarks to be achieved by 2015 with health at the core of the development process. The changed paradigm necessitated development of new competencies and skills, such as leadership and team building, management skills, technical competence, interpersonal communication skills, inter-sectoral coordination, networking, partnerships, financing of health care and social skills.

Dr Gupta felt that the current status of public health was ‘agonizingly’ low: it was not recognized as a specialty like clinical areas; the discipline did not attract young talent; the career structure was not well defined, and opportunities for career development were limited. In addition, the competence and skills among public health professions were limited; the training in public health was of poor quality, and public health schools were not getting appropriate support.

Career development in public health was crucial to make the public health profession attractive, enhance the image of the organization, increase commitment, motivation and performance. Creation of career development opportunities would help exploit fully the human resource potential. Discussing the various stages of career development, Dr Gupta suggested how at each stage specific career development approaches could be adopted. Public health offered several career opportunities, such as teaching, research, public health system, international organizations, NGOs, the private sector and others.

Dr Gupta cautioned that career development should not be viewed in terms of promotions only, but as capacity building involving knowledge, competence and skills. It essentially required selection and recruitment of persons with the right aptitude for public health with genuine interest in public health career. Its ultimate aim should be to create a learning organization, with a shared vision and personal mastery through continuous

knowledge building and learning, team learning and working, systems thinking, and mental models with positive thinking.

The participants made the following comments:

- (1) Public Health education should be a component of training and orientation programmes for all health professionals, including doctors, midwives, and health assistants. Nursing staff and paraprofessionals, who are the main components of the public health workforce, also need to be imparted public health skills.
- (2) All MPH courses should be open to both medical and non-medical professionals. To promote “public health” as a discipline, special attention should be paid to provide access to other health professionals besides medical graduates to become public health professionals. Countries could draw useful lessons from Thailand and other countries’ experiences in offering MPH to other health professionals.
- (3) There is need for a reliable and updated database of public health institutions.
- (4) The producers (public health training institutes) and the users (community or health services) should strive for better coordination towards producing public health professionals to meet the country’s needs.
- (5) Talent should be identified and nurtured/encouraged to take up careers in public health. To attract young talent, the ministries of health and public health institutions should focus more on social marketing and wider dissemination of information on career development pathways. The ministries could consider offering scholarships to undergraduate health/medical students to attract them to join public health posts after their graduation.
- (6) A positive self-image needs to be developed in the minds of students in the medical colleges. With the high level competency required, specializing in public health could become highly rewarding financially.
- (7) Thailand’s pioneering approach of levying a 2% ‘Sin Tax’ on alcohol and tobacco is an innovative effort at resource mobilization. The tax, which goes into a Health Fund, is used for health promotion activities. Already, millions of dollars have been utilized this way.

This approach needs to be studied for possible adoption in other countries.

- (8) Public health qualifications should be reviewed in the generic sense, and opportunities provided for super-specializations, like health planning, health management, etc.
- (9) As part of cadre restructuring, a detailed analysis of knowledge, skills and attitudinal requirement for public health management positions should be undertaken. Seven Indian States have already effected such cadre restructuring.
- (10) Career development should include the development of vision, competence and skills. Potential appraisal is critical for career development and opportunities should be created for talented public professionals including job rotations. A career path must be developed and clearly communicated.

Detailing the “**Educational Reforms in Public Health**”, **Dr P.T. Jayawickramarajah**, Coordinator, Strengthening of Health System, WHO/SEARO stressed the perceived need to re-define the role of public health in evolving systems. This required meaningful coordination between the different medical specialties as well as with other allied health professions. This, in turn, called for radical reforms in the education of both providers of individual care and practitioners of population-based medicine.

Dr Jayawickramarajah traced the reforms pioneered by WHO in medical, nursing and allied health professions education in the Region since early 1980s. A consensus appeared to be growing that training in public health and family medicine should address challenges resulting from changing demographic and epidemiological transition and effects of globalization on the health system. Dr Jayawickramarajah identified inclusion of additional subject content and disciplines; management of technological revolutions in health and information systems; and utilization of pedagogical innovations as some of the essential areas meriting consideration.

Making a strong case for integrating public health professions with others in the systems in which they would operate later, Dr Jayawickramarajah said that this would provide enhanced opportunities to professionals to apply their recently acquired knowledge and skills in practical context. Health was no longer a sectoral development subject, but an integral part of many sectors, like housing, education, industry, agriculture, trade and transport services. He

stressed the need for these professionals to interact and thereby to enable health care in areas such as school health, health in workplaces and municipalities.

Identifying 'field epidemiology training' as a weak area in public health training in SEAR countries, Dr Jayawickramarajah urged strengthening the capacity of public health institutions with appropriate expertise and revising curricula to provide opportunities for students' practical training for cost-effective and timely action. Although the emphasis of public health activities might change, the objectives of health protection and promotion, and disease prevention and control (based on epidemiological analysis and multidisciplinary research inputs) remained constant.

The inter-regional meeting on New Challenges for Public Health, held at Geneva, during 27-30 November 1995, had identified the following seven major categories of public health training:

- (1) Post-basic and postgraduate training for public health professionals;
- (2) Pre-service training for public health workers (community health worker, family health worker, lady health visitor, etc.);
- (3) Public health content in pre-service training of other health workers (medical, nursing and allied health);
- (4) In-service training of health personnel;
- (5) Continuing education of public health workers;
- (6) Public health content in the training of workers in related sectors (teachers and social workers), and
- (7) Public health training of the community.

Dr Jayawickramarajah said that WHO/SEARO had facilitated Member countries define competencies for categories 1 to 3, while for categories 4 to 7, the required competencies were yet to be defined. He suggested that continuing professional education should be considered in a systematic manner. Limited experience with studies in India and Sri Lanka had shown that very little attention was given to continuing education in all areas of health sciences including public health.

In traditional health professional curricula, public health was taught as an isolated discipline through lectures. At a variance from this focus on biological perspectives, innovative schools were considering population and behavioural

perspectives in an integrated manner. Dr Jayawickramarajah suggested the following innovative areas as desirable in reforming public health education: problem-based learning, multi-professional education, inquiry-driven approach to learning, utilization of information technology, and continuing professional education.

During the discussions, the following points emerged:

- The major SEARO activities that followed the Calcutta Declaration (1999) were primarily linked with public health education, and were less related to public health services.
- Public health teachers performed only limited public health practice, and public health practitioners had limited exposure/involvement in academic activities.
- Public health decisions were, by and large, in the hands of non-public health professionals, as a result of paucity of well-qualified public health professionals.
- Medical audit, as per ICD-10, is essential and MDG (Millennium Development Goals), should be incorporated in the Public Health curriculum.
- Reform should not be limited to formal post-graduate education in public health, but extended to short-term, non-formal training for all levels of personnel.
- Public health professionals needed to interlink with the public health system.
- It was crucial to introduce behavioural sciences to health professionals during their training.
- It might be necessary to establish “Public Health Councils” at par with other professional councils, such as medical, dental and nursing councils.
- Volunteers, who performed a vital function in conflict situations, needed to be involved in the mainstream of health services when conflicts were resolved.

Elaborating on ‘**Challenges of Strengthening of Health System through the Primary Health Care Approach**’, Dr Tej Walia, Regional Adviser, Health Systems Development, WHO/SEARO, said that extending health-enabling conditions and quality care to all is the imperative for health systems. The

core principles and elements of PHC remain valid and appropriate. An approach to the development of health care driven by PHC must aim at universal access to quality health care services.

There is a need to redefine, adjust and strengthen the PHC approach in the context of the new and emerging health care issues, e.g., HIV/AIDS, SARS, etc. Since Alma-Ata, dramatic changes had occurred in the patterns of disease, in demographic profiles and in the socioeconomic environment presenting massive new challenges to public health. Increases in the preventable risks and chronic, noncommunicable diseases as well as violence, threatened societies already burdened by communicable diseases. Globalization, the changing role of governments, involvement of the private sector, poverty and macroeconomics and advances in technology are other changes that need to be addressed in strengthening public health systems.

Other major challenges faced by the health systems in the Region were the inequity in health and the need to strengthen community involvement – including the dimensions of participation, ownership and empowerment. The profit-oriented approach and privatization of health care without effective regulatory systems had a negative impact on people's health. Furthermore, there had been a major shift of the health workforce into private practice.

Investments in the health workforce, which consumed two-thirds or more of a nation's health budget, should be carefully reviewed to ensure availability of an adequate number, type and distribution of health professionals. Dr Walia stressed that the health system should be patient-centred (with care that respects and responds to individual patient preferences, needs and values), safe, effective, accessible and efficient.

The health sector must take the prime responsibility to foster a multi-sectoral, multi-disciplinary approach for the development of appropriate resources for health, achieving equity in health status by undertaking more effective measures for disease prevention and health promotion.

Dr Than Sein, Director, Evidence and Information for Policy, WHO/SEARO, made a presentation on the '**Millennium Development Goals**'. The United Nations Millennium Declaration, adopted at the Millennium Summit organized by the United Nations in New York in 2000, had set out the principles and values that should govern international relations in the 21st century with specific commitments in seven areas. The road map

prepared following the summit established goals and targets to be reached by 2015 in each of these areas. The goals in the area of development and poverty eradication, now widely referred to as the Millennium Development Goals (MDGs), placed health at the heart of development, thus providing an opportunity for concerted action to improve global health.

Dr Than Sein said that the MDGs established a novel global *compact*, linking developed and developing countries through clear, reciprocal obligations to do more to reduce poverty and hunger and to tackle ill-health, gender inequality, lack of education, access to clean water and environmental degradation. Three of the eight goals (viz., reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases) are directly health-related; all of the others have important indirect effects on health.

The International Conference on Financing for Development held in Monterrey, Mexico in early 2002 had further developed this idea of the MDGs as a *compact*. The resultant Monterrey Consensus reaffirmed the importance of the MDGs and provided a framework for building the partnerships needed to achieve them. The World Summit on Sustainable Development, held in Johannesburg, South Africa, in September 2002, recognized that poverty reduction and the achievement of the MDGs were central to the overall sustainable development agenda. Both the *World Development Report 2003* and the *Human Development Report 2003* had further developed the concept of a compact, with a view to informing policy.

WHO's Commission on Macroeconomics and Health had highlighted the two-way causal relationship between economic development and health, to underline the crucial role of health in economic growth. The importance of health within a multidimensional model of sustainable human development was also a key message of the MDGs.

While improvements in health are important in their own right, better health was also a prerequisite and a major contributor to economic growth and social cohesion. Improvement in people's access to health technology was a good indicator of the success of other development processes. The MDGs recognized all such relationships with three of the eight goals, nine of the 18 targets required to achieve them, and 18 of the 48 indicators of progress being health-related.

The MDGs would help assess and track progress in development on a number of critical fronts. Dr Than Sein cited the example of Goal 4, Target 5, viz., achieving a two-thirds reduction in child mortality. This was perhaps the most challenging and the furthest of all the health-related goals from being realized. It required technical interventions aimed at tackling the major causes of child deaths, such as malnutrition, infections and parasitic diseases. These interventions, mediated through a network of public and private delivery systems, depended on adequate levels of financing to be effective. Actions to ensure greater food security and access to education, essential medicines and clean water, and improvements in public expenditure management would reinforce their effect.

Dr Than Sein provided a brief overview of the progress of the Member Countries in the Region towards achieving the MDGs. He stressed the need for significantly strengthened commitments from both wealthy and developing countries, to meet the goals globally.

The following comments were made during the ensuing discussions:

- Measuring MDGs was a challenge for the governments and institutions. So was the measuring of indicators related to PRSP, ICPD+ sector strategies.
- The varying methodologies used in surveys conducted by different agencies had raised concerns over their reliability and also the validity and comparability of indicators of MDG.
- WHO had a special role to play in validation and comparability of indicators of MDGs.
- While countries had adopted MDG goals supported by politicians, the public health specialists should implement these by linking with committed politicians.

4. PLENARY SESSION 2 (THEMATIC SESSION)

Challenges, Opportunities and Constraints for Improving Public Health as a Discipline

Describing '**Constraints and opportunities for improving public health in practice**', **Dr Ahmed Al-Kabir**, Chief of Party, Unity for Helping Partners (UFHP), Bangladesh, provided an overview of public health and posed

questions on the understanding of public health, need for a common definition, what constituted the public health workforce and the reason why public health was needed now more than ever. He identified six major areas for improvement of public health in practice: location, economic issues, gender issues, programme elements, service type and governance.

Dr Kabir provided a comprehensive list of constraints and opportunities relating to public health practice. He stressed the need for high level commitment from political leaders, bureaucrats, policy makers and professionals at all levels (doctors, midwives, skilled attendants, fieldworkers etc.). Sharing of experiences, partnerships, replication of success stories and involvement of the private sector were considered as opportunities for meeting the growing needs of the programmes. In conclusion, Dr Kabir encouraged the WHO to continue its leadership role and support networking, partnerships and technical assistance for positioning PH in a lead role in the Region.

During the ensuing discussions, the following points were raised:

- Public health practice required close co-ordination with curative health services for their effective and efficient conduct. Multi-sectoral efforts were required to address the socio-cultural norms in health seeking behaviour of communities. The “healthy settings” concept could be used to promote inter-sectoral collaboration for health at local levels.
- Nutrition, including food security and food safety, formed an important component of public health.
- Public health needed to be more respected; this might require enactment of legislation.
- The emphasis of public health activities should be to achieve the objectives of health promotion and protection, and disease prevention and control based on epidemiological analysis and multi-disciplinary research inputs.
- Community “ownership” of health services would be relevant for decentralization of health services. Grass-root level ownership of primary health care programmes could be encouraged. Nepal had successfully practised this intervention at village development committee (VDC) level through its “revolving drug” scheme.

Describing the challenge of '**Public Health in conflict situation**', **Dr S. Kumaravetpillai**, Director, Provincial Directorate of Health, North-East Province, Sri Lanka, cited the instance of primary health care in the North-East Province of Sri Lanka. The civil war, which lasted for over two decades, had severely damaged the health systems in the Northern and Eastern parts of the country. Infrastructure facilities were lost or damaged leading to mass exodus of medical and paramedical personnel and skilled employees to the southern parts and even to other countries.

To tackle the challenge, the provincial health department had joined hands with national, multi-lateral and international agencies, NGOs and volunteers from the local community. Mobile medical clinics were arranged to provide preventive and curative services with the cooperation and participation of agencies like ICRC, MSF and SLRC. Health volunteers, recruited from the community, were trained by public health staff and also by NGOs, and deployed to provide primary health care to the unreachable areas where clinics were conducted in temporary buildings and even under the trees and tents in certain places.

Highly motivated staff was responsible for conducting successful immunization programmes. The Liberation Tigers of Tamil Eelam (LTTE) and government forces observed a cease-fire on the National Immunization Days for Polio and Measles, called "days of tranquillity". Health staff transported vaccine carriers by bicycles to remote areas, and joined volunteers in conducting health education programmes on priority communicable diseases, sanitation and water supply.

Dr Kumaravetpillai emphasised the need for providing health care services to displaced families, and reconstruction and rehabilitation of the war-affected health facilities. Sri Lanka had mobilized funds from the NECORD and the NEERP programmes of the Asian Development Bank, the Government of Netherlands, OPEC and the World Bank. Dr Kumaravetpillai enumerated some setbacks to the efforts at providing health services from lack of human resources, and suggested decentralization to the provincial level of recruitment, training and appointment, and temporary lowering of qualifications for recruitment of Female Health Workers. He hoped that the health services would be re-established at par with the rest of the country in 2 to 3 years' time.

Group Work on Theme 1

In the Group Work session that followed, the participants identified constraints and made recommendations for improving public health as an essential discipline.

Constraints: The Consultation identified the following possible constraints to improving public health as a discipline in the countries:

- Lack of adequate sensitivity among policy makers and administrators to public health-related issues.
- Disproportionately higher allocation of government funds for curative care as compared to public health activities.
- Low status of public health work as compared to other specialties.
- Absence of a career path/structure in public health.
- Frequent inability of public health professionals to reach out or involve the community.
- Inadequate capacity of public health specialists.
- Lack of a comprehensive teaching/training component and faculty.
- Lack of inter-sectoral coordination with related areas.
- Failure to focus on the poor, vulnerable and the under-privileged.

5. PLENARY SESSION 3 (THEMATIC SESSION)

Health Systems Research

In his presentation on the role of '**Research in Public Health**', **Dr B.A. Jayaweera**, WHO Temporary Adviser, elaborated on the importance of such research in relation to the objectives of the consultation. He stressed the fact that it was not research but the use of research that would lead to transformation of social and political processes for more equitable health service provision. Thus, to be effective, research should alert policy-makers to problems and provide information for assisting decisions on appropriate action. Researchers in public health could play a vital role as advisers to policy-makers and bring research findings, with clarity, to the attention of a wider range of advocates for policy change. Research results must be articulated in terms easily understood by the public, policy advocates and decision makers.

Dr Jayaweera discussed the role of applied and basic research, and detailed the various research methods including quantitative and qualitative approaches and impact measurement. Public health research ethics posed important concerns over informed consent, confidentiality, patient rights, best care following research, and the legal framework. He emphasized the need for leadership in public health research with efficient management, public relations, and regular use of communication and partnership with the media in achieving change and in implementing policies and programmes. Strategies needed to be evolved to attract funds, and convert research into practice.

Dr Jayaweera listed the major country concerns as resource mobilization, sustainability, development of a critical mass of researchers, co-ordination of limited resources, creation of focal points for concentration of resources, concerns about donor dependence, and capacity-building for use of research results. Besides basic research and technology studies, Public Health Research, especially Health Systems Research, could study the imbalance in equity and access and help determine the best compromise option. These new trends might give respectability and accord recognition to Public Health with the provision of resources including funds. Such research could help countries focus on the root cause of their burden of disease, namely poverty, exacerbated by structural inequity and sometimes, armed conflict.

Many universities and PHIs in the region lacked a critical mass in the range of public health disciplines necessary for comprehensive research; the few skilled researchers who exist were overloaded. Stimulating demand for research results had been neglected compared to the supply of researchers. Trained researchers often experienced frustration where the policy and service environments were not conducive to implementing research findings. Sometimes, the research effort was duplicated, especially in relation to 'fashionable' research topics. The research agenda and priorities arose from the complexities of problems faced and comprehensive system-wide and cross-sectoral approaches to address them. Dr Jayaweera advocated building on work already done and drawing lessons from comparative analyses as mechanisms to move forward more quickly and to make effective use of scarce research resources. He cautioned, however, that to have relevance and impact, comparative research must be rooted in, and not merely draw on, country experiences.

Dr Jayaweera said that public health research could provide countries an opportunity to think anew about strategies for influencing health reform and health systems development. There was need for research studies on health insurance, regulation of the private sector, addressing inequalities, decentralization, the overall design of reforms and impact of reforms on efficiency and equity, provider organizations and management, and human resource planning, deployment and management. For promoting research in public health in the Region, Dr Jayaweera suggested the formation of Task Forces and Scientific Working Groups with the active involvement of heads of collaborating centres, resource persons, donors, chairman/representatives of the Advisory Committee on Health Research and WHO staff from HQs and other regions. He discussed the possible role of a Steering Committee, with the Secretariat based at the Regional Office.

Dr Jayaweera felt that the proposed PHI network could play an important role in stimulating the demand for public health results and in developing effective national and local networks as pivotal strategies for capacity-building. It should aim to enhance synergy, avoid duplication and maximise use of scarce public health research resources. Assisting countries to develop and follow criteria for establishing their priorities for public health research would be seminal in achieving effective use of scarce research resources.

The network could promote capacity development with a more dynamic interchange among health policy researchers in different disciplines, who tend to work on the same problems but “on separate islands”. For example, models for community health financing would benefit from inputs from economists, other social scientists, epidemiologists, other biomedical researchers, and the community itself. It could also play an important role in brokering the interaction between regional or national public health research needs and international research agendas, which need not necessarily, but often were in conflict.

Reviewing the role of **‘Health Research System (HRS) in Strengthening Public Health’**, Dr Adik Wibowo, Regional Adviser, Research Policy and Cooperation, WHO/SEARO said that health research was essential to improve the design of health interventions, policies and service delivery. HRS comprised people, institutions and activities whose primary purpose was to generate relevant, high quality knowledge that could be used to promote, restore and/or maintain the health status of populations. HRS could include the mechanisms adopted to encourage the utilization of research.

Dr Wibowo explained the position of HRS within the national research systems and the health system. Its goals were to advance scientific knowledge and utilize this knowledge to improve health and health equity. It could contribute to social outcomes, such as knowledge, health, human rights and economic growth. HRS was the brain of the health system and was the tool to organize and understand the health system and for ensuring its effective operation. HRS could help define and articulate vision, identify appropriate research priorities, setting and monitoring ethical standards, secure research funds and their allocation, build, maintain and strengthen human and physical capacity for research.

Dr Wibowo reviewed the key policy issues in HRS, such as research resource, utilization of knowledge and capacity building. While traditionally priorities in health research were formulated in terms of diseases and conditions, there was now increasing realization that this was only one dimension of health research and that health determinants themselves had to be prioritized and were competing for the same funding as disease-focused priorities. Two other dimensions to health research also had to be prioritized against the others, i.e., methodologies for priority-setting and cross-cutting issues in health research, such as, poverty and health, gender and health, and research capacity strengthening. Besides targeted research funding based upon the 'burden of disease', the Commission on Macroeconomics and Health had recommended annual global funding of \$1.5 billion on disease epidemiology, health economics, health systems and health policies as they affect people in poorer nations.

Dr Wibowo said that PHIs could play a stewardship role for HRS as focal points, prime movers or think tanks for good governance in health research, as research is a part of the university's mission. They could focus on the country's needs (rather than be driven by donor's needs), and be involved in setting national research priorities, setting research policy and planning health research agenda.

PHIs could also help in capacity development through production of researchers, improving the skills of researchers and research managers, developing and implementing curricula on research methodology, research management and research ethics, facilitating training and public debate, and in exchange of students and faculty. They could also facilitate knowledge generation and bridge the gaps between researchers and policy makers through balanced research methodologies and library networks.

Resource mobilization was yet another area where PHIs could help. They could identify research funders, obtain funding, form research review committees, fund small research, promote young researchers, and promote partnerships and networking. Dr Wibowo emphasized the need for allocation of adequate resources for health.

Group Work on Theme II

Group work followed the presentations and discussions on Health Systems Research. The group reports were presented and finalized in a Plenary Session.

- (1) The group identified the following types of research that could be undertaken by PH institutions:
 - Multidisciplinary involving other departments or sectors/multi-centric, multi-country.
 - Identify thrust areas – those subjects/topics that are of immediate relevance.
 - Develop data required for policy formulation and identify institutions.
 - Health systems operational research for capacity building, measuring impact, allocation of resources.
 - Health impact analysis and formulation of guidelines.
 - Research to cover basic, applied, qualitative, quantitative, predictive, prospective, operational research, systems analysis, etc.
 - Development of disease control/prevention models and their pilot testing.
 - Development of mathematical and epidemiological models of diseases.
- (2) The group felt that research could help promote public health as a discipline, and could promote public health in the Region by:
 - Generating evidence for framing policies and strategic planning.
 - Expanding knowledge base of existing concepts.
 - Setting and monitoring standards.

- Promoting advocacy for healthy public policies and programmes.
- Translating policies into action through programme planning, implementation, monitoring and evaluation.
- Serving as entry points through research outputs to effect changes and assess their impact.
- Generating valuable data-bases that could facilitate sharing of knowledge, skills and information, and form a basis for comparison and reference from grass-roots to central level for policy makers and programme implementers.
- Capacity building with increased research activity leading to a greater demand of public health, and
- Networking between PH related organizations.

It was also felt that research data could be shared among PHIs through available information technology.

Key roles for WHO

- Capacity building for research
- Support for resource mobilization
- Working with countries in setting country-specific public health research priorities
- Documentation and dissemination of results.

6. PLENARY SESSION 4 (THEMATIC SESSION)

Structure and Operationalization of a Network of Public Health Institutions in the Region

Describing 'Thailand's Experience of Networking in Public Health', **Dr Chalermchai Chaikittiporn** from Mahidol University, Bangkok, mentioned that networking of public health organizations was established over five decades ago. The focal organizations were at the Ministry of Health and the Bangkok Metropolitan Administration. The initial phase from 1950-70 involved collaboration in implementing projects, helping design interventions,

monitoring and evaluating health projects and programmes, providing consultations, and establishing the Health Professionals Association (HPA).

The second phase (1971-90) witnessed the establishment of networking among the HPA and the National Committee for Government and Nongovernmental Organizations working at policy level. The third phase, from 1991, focussed on partnerships, use of a multi-disciplinary approach, and application of healthy civil society, and networking with local authorities in health-related issues.

Dr Chaikittiporn mentioned that the other networking, among PH educational institutions within the country, was of more recent origin. Started in 1997, it involved 15 institutions spread across four regions of Thailand. The objectives were to formulate professional public health standards, cooperate in teaching-learning process, research and resource sharing, faculty staff development, and launch health-related activities/projects. Initially, the core institution in this network, the Mahidol University, conducted meetings with the other five institutes informally, and convinced PHIs to be network members. Annual meetings were conducted at the national level, while the networking committee held monthly meetings with each institute.

A number of joint projects had been taken up by the network. These include the accreditation of PH educational institutions, cooperative research networking, and the establishment of the PH Education Institutions Association. Future plans include establishment of a Council of Education for PH, linkage with SEA member countries for networking of PHIs, and with APACPH, and conducting annual international workshop/forum among member countries of the network.

Dr Monir Islam, Director, Family and Child Health, WHO/SEARO, reviewed the '**Possible Models for Networking**' and discussed their merits and limitations. He suggested that the terms of reference could include promotion of collaboration among staff, promotion of capacity building, and collaboration in education, training and research, and providing technical backstopping. The activities could cover information exchange, sharing experiences on institutional development or quality, collaborative/multi-centric research, undertaking joint programmes on education and training, developing and accreditation system and maintaining a database.

Dr Islam asked the participants to deliberate on the structure and functions of the network. He suggested that while initially WHO could act as

the Secretariat for the network, later one institution from each country could perform this role by rotation. He discussed the pros and cons of fixed vs. rotation in Secretariat. Identification of focal persons in institutions or at international level would promote better coordination, and help monitor progress.

Dr Islam stressed the need for monitoring progress through annual meetings of the sub-network and the inter-country network, theme-based or emerging issue-based meetings, and network publications. Network maintenance would require system incentives and adequate funds.

This was followed by Group Work on the structure and operationalization of networking of PHIs in the Region. The Group reports were presented and finalized in a plenary session. The group recommendations are included in the final recommendations.

7. PLENARY SESSION 5 (PANEL DISCUSSION)

Role of Public Health in Disease Control Programmes

What role do public health training institutions have in disease control?

Dr Sulochana Abraham, Head of Community Health Department, Christian Medical College, Vellore, India, said that these institutions play a vital role in imparting knowledge, skills and attitudes to an array of health personnel including under-graduates and post-graduates in medical and nursing disciplines, and allied health sciences, grass-root level workers, supervisory level staff, self-help groups, formal and non-formal community leaders, and traditional practitioners. The resource persons include departments, other sectors, NGOs, government agencies and the community. Public health cannot be taught in a vacuum and these institutions needed to have a field practice area or community.

Detailing the teaching activities, Dr Abraham said that these could be carried out by education, training, service, research including basic/advanced, operations research and participatory research, outbreak investigation, use of MIS and GIS, timely referral, appropriate preventive measures, monitoring and surveillance, and changing concepts. For making their work sustainable, the institutions could build and demonstrate lasting partnerships with communities, using all available resources, private practitioners, inter-sectoral collaboration, and government and policy makers.

What role does Epidemiology play as a public health tool in the control of diseases? **Dr Mahmudur Rahman**, Director, National Institute of Preventive and Social Medicine (NIPSOM), Dhaka, Bangladesh, projected epidemiology as an important public health tool in disease control. The various post-graduate courses on public health organized at NIPSOM contained epidemiology as a core element. Epidemiology played an important role in understanding the cause and mechanism as distinct from the necessary or specific cause of diseases. The mode of transmission was important in minimizing morbidity and mortality in different situations. Also, it was an important tool in diseases with multiple risk factors in communities, e.g., AIDS and Hepatitis B. The behavioural risk factors were different for each country for different diseases, he said.

Most appropriate interventions could be adopted using epidemiological methods as was done when arsenic was traced in groundwater in Bangladesh. The extensive epidemiological data gathered for this problem helped policy makers find interventions and establish priorities.

Surveillance with respect to risk factors was a very important public health tool for the control of communicable and noncommunicable diseases. With the help of epidemiological data, mere alteration of the risk factors had helped to reduce the incidence of some of noncommunicable diseases.

What is public health's role as a primary player in the control of communicable diseases? **Dr Jai P. Narain**, Coordinator, HIV/AIDS and TB, WHO/SEARO, said that there were two scenarios as far as the role of public health was concerned. One was where public health was the primary player, e.g., TB within the domain of public health and secondly, public health as part of multisectoral response, e.g. AIDS. Traditionally, TB control was the responsibility of the health services. Case management, diagnosis and treatment was a public health problem. Preventing TB at the source – treating, curing and breaking the chain of transmission – was within the domain of public health. There was primarily one process indicator and one outcome indicator. These were measured along with targets on a quarterly basis. Having simple targets and measuring them on a timely basis was helping to closely monitor the ongoing control activities, while developing or planning effective strategies.

Public health could play its operational and technical role in planning, in mobilizing other sectors and providing technical support in implementing the overall programme. In addition, there were several areas where public health

could play an important role such as investing in health of the poor, creating awareness on the centrality of health in economic development, Millennium Development Goals, Global Fund Initiatives, etc. If we are innovative, we can make use of these resources in improving public health, he said.

To sum up, there were five concrete areas where public health should play a crucial role – political commitment and leadership in terms of policy, allocation of resources, etc.; strengthening national capacity and infrastructure; scaling up cost-effective interventions in priority health problems; responding to emergencies; and mobilizing partnerships. That's why public health enjoyed a high priority both in terms of policy and practice.

Dr Narain clarified that one of the reasons for low case detection in TB was because the community was not availing the DOTS services wherever available. There could be three possible strategies to tackle the situation: firstly, community education, secondly, public-private partnership where in some pilot projects the cure rate had reached 60% and thirdly to improve the quality of TB services.

As far as prevention of HIV/AIDS was concerned, inter-sectoral collaboration, including involvement of NGOs at the community level in HIV control, was the key strategy. The HIV control programme was involving other sectors in planning, implementation and evaluation. In Global Fund, there are country coordination mechanisms. During discussions on the Global Fund for AIDS, TB and Malaria, it was asked why resources should be deployed for supporting the three vertical programmes of AIDS, TB and malaria while these could be used to support development of health systems. However, it was agreed that these were the main causes of morbidity and mortality and, with additional resources, it would be possible to build and strengthen health systems.

What is the role of health authorities vis-à-vis water, sanitation and hygiene determinants of health? **Mr Terrence Thompson**, Regional Adviser, Water, Sanitation and Health, WHO/SEARO, said that this question was important because, according to the World Health Report 2002, unsafe water, sanitation and hygiene were the third most important risk factors in developing countries with high rates of mortality. Since the introduction of oral rehydration therapy in 1979, control of diarrhoeal diseases programmes, in conjunction with other interventions, had achieved a marked reduction in deaths due to diarrhoea in the South-East Asia Region. Unfortunately, however, diarrhoea caused greater mortality and a greater burden of disease

than HIV/AIDS, TB or malaria. Most of the mortality and morbidity caused by diarrhoea occurred among children. Other water and sanitation-related illnesses, such as typhoid, hookworm, and trachoma were also of concern to health authorities in this Region.

Mr Thompson observed that SEA Region was on par with Latin America regarding water supply coverage but that disparities existed among social classes and geographically within countries. Importantly too, quality of drinking water remains a major issue and few public water supply systems can guarantee the safety of drinking water. SEA Region has the lowest sanitation coverage of any WHO Region worldwide, and studies have documented poor hygiene practices especially in rural communities and urban slums. Concerned with the current situation, the 56th Meeting of the WHO Regional Committee for South-East Asia adopted a resolution, which endorsed a role for health authorities as evidence-based advocates for improved water supply and sanitation, and promoters of cost-effective strategies to improve water supply and sanitation services and to improve hygiene practices. Effective advocacy depends on good information and therefore there is a need for health authorities to stimulate and support research into WSH issues, to link disease surveillance with environmental surveillance, and to strengthen their capacities in information management and communications. Mr Thompson cited the Region's eradication of guinea-worm disease during the 1990s and hailed this as a model of successful inter-sectoral cooperation in favour of health, which should be emulated to reduce other water-related illnesses, especially diarrhea. Linkages needed to be strengthened between ministries of health and authorities responsible for water supply and sanitation services for this purpose.

Are noncommunicable diseases (NCDs) emerging as a serious public health challenge in the South-East Asia Region? Answering this query, **Dr Jerzy Leowski**, Regional Adviser, Non-communicable Diseases Surveillance, WHO/SEARO said that unhealthy behaviours like tobacco use, physical inactivity and inappropriate diet were contributing to an increased burden of NCDs. In the South-East Asia Region, there were an estimated 7.42 million deaths from noncommunicable conditions and 1.47 million deaths from injuries in 2002. The burden of disease due to NCDs in the Region was estimated at 186.4 million DALYs, and that due to injuries at 55.5 million DALYs in 2002.

Dr Leowski reported recent developments in the regional NCD surveillance prevention and control programme. He highlighted the role of public health in agenda setting, guiding policy development, capacity building and reducing health inequalities. He recommended promoting the appropriate use of health services, providing skills for imparting effective health education, influencing the policy making process, and fostering social support. Educational programmes, he said, should target the general population, communities, at-risk groups, patients, medical students and health professionals.

7. PLENARY SESSION 6

Conclusions and Recommendations

The conclusions and recommendations of the consultation were presented by the rapporteurs and finalized at a plenary session on the fourth day. Intense discussions centred on what should be the key strategies and actions that should be pursued by the countries and WHO in promoting and strengthening public health services, education and research in the Region. The consensus was that, while the achievement of a sustainable system was likely to involve concerted action over a period of time, it was possible to initiate strategic actions that would give an immediate boost to the current status of public health in all its dimensions. These ideas are presented in detail in the section on Recommendations of the consultation.

8. CLOSING SESSION

Addressing the valedictory session, **Dr Samlee Plianbangchang**, Regional Director-Nominee said that the regional consultation was another step forward in the development and strengthening of public health education and practice in the Region. WHO would spare no efforts in providing necessary support for implementing them, subject to availability of resources. While stating that medicine deals primarily with care of individuals in the institutional settings, he said there is a big overlapping area. In the light of a dynamic change in the health area today, this difference would be increasingly seen. Medicine and public health were the two pillars supporting each other. The tools used in public health were different from those used in medicine. However, many tools were used together.

Therefore, there was a need for multidisciplinary and multisectoral actions to achieve public health goals, through the development and implementation of public health programmes, such as health education, nutrition, water and sanitation, malaria control, tuberculosis control, prevention of drug addiction and mental health, for example. Public health education cannot be seen to be the same as medical education, even though they greatly related and supported each other.

To achieve measurable results during the next few years in strengthening public health education and practice in the Region, clarity in the principles and concept of public health was needed. "We also need to have a clear focus in our work. To strengthen public health in the Region, it was most important to pay urgent attention to human resource development for public health. That would be one of my overriding priorities when I assume the office from the first of March next year", Dr Samlee said.

A high-level professional task force to work out a framework in this regard to help and a specially dedicated group at the Regional Office would be established to provide secretariat support to the task force, Dr Samlee added.

Dr Uton Muchtar Rafei, Regional Director, WHO/SEARO, in his closing remarks, expressed satisfaction with the fruitful deliberations, and the constructive and pragmatic recommendations made by the participants towards achieving the objective of the consultation. A number of activities and recommendations had emerged out of this consultation on areas such as operationalization of networking of public health institutions in the Region, research in the field of public health and improving public health as a discipline in the countries of the Region. He assured that WHO would consider these recommendations seriously for implementation in the Region.

Referring to the short courses for public health executives at the University of Padjadjaran as a very important milestone, Dr Uton said that these could be expanded and similar courses conducted at other regional institutions. He appreciated the contributions of the Chulalongkorn University, Mahidol University, CMC Vellore, Institute of Health Management Research, Jaipur, NIPSOM, Dhaka and the University of Indonesia in taking a lead role in Networking.

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The Calcutta Declaration was a very significant event that facilitated the promotion of public health in the Region. Dr Uton stressed the need for all countries in the Region to recognize public health as a crucially important discipline and a specialty, and its role in developing effective and efficient health systems. He said that networking of public health institutions, developing partnerships, and strengthening research programmes in public health would have an important role in facilitating development of effective and efficient health systems in the countries of the Region. Some countries like Thailand and Indonesia had already achieved progress in this direction, and other countries could follow their example.

RECOMMENDATIONS

Education and Services in Public Health

For Countries

- (1) Where it is not yet in place, institute a cadre for public health professionals at the central, state/ province and district levels.
- (2) Strengthen PH teaching institutions, mainly through capacity building.
- (3) Strengthen leadership and managerial capabilities of PH professionals through training.
- (4) Network and share experiences among all stake-holders (institutions, associations, organizations, etc.), including local governments.
- (5) Strengthen collaboration among PHIs and other national programmes, particularly linking with poverty-related issues and initiatives.
- (6) Organize regular refresher courses for all public health professionals on issues related to public health.

For WHO

- (1) Establish a SEAR Forum on Public Health where organizations, institutions, associations and individuals can participate.
- (2) Identify and mobilize resources for strengthening PH Institutes (and departments).

- (3) Perform an advocacy role for promoting adoption of national policies conducive to promotion and strengthening of public health as a discipline.
- (4) Support establishment and strengthening of regional and national institutes, such as WHO Collaborating Centres.

Research in Public Health

For Countries and PH Institutions

- (1) Countries should use evidence-based research in public health policy – formulation.
- (2) PHIs should undertake research, preferably multi-disciplinary and multi-centric, in thrust areas, such as health systems operational research for capacity building, measuring impact and resource allocation.
- (3) Countries and PHIs should collaborate to improve their capacity in research through appropriate networking between PH-related organizations.

For WHO

- (1) Support the countries and PHIs to build their capacity for research through technical collaboration and support for resource mobilization.
- (2) Work with countries in setting country-specific public health and healthy public policy research priorities.
- (3) Support countries with documentation, dissemination and utilization of research results.
- (4) Guide formation of a network of PH research institutions, and creation of a platform for policy makers, researchers, PH specialists, etc.

Draft Plan for Operationalizing the Network of Public Health Institutions in the Region

The consultation recommended the formation of the South-East Asia Public Health Education Institutes Network (SEAPHEIN) involving PHIs in Member Countries of the Region, with the objective to strengthen the capacity of the

network's member institutions to enhance public health capabilities through teaching/training, practice and research.

Terms of Reference for the network

- (1) Promote collaboration among personnel in public health and related areas.
- (2) Promote capacity building in terms of knowledge, attitude and skills in the field of public health.
- (3) Promote collaboration in education/training, research and practice of public health, including inter-institutional collaboration in education/training, research, service, and development and access to technical resources.
- (4) Provide technical and consultative services in the above areas and strengthen technical cooperation in the Region.
- (5) Facilitate mobilization and sharing of resources (including information) towards optimizing their utilization.
- (6) Contribute to international collaboration through linkages between this network and other networks of similar nature at regional and global levels.
- (7) Promote improvement in the development and management of WHO collaborative programmes.

Activities for the network

The activities suggested for the network include:

- (1) Development and coordination of joint programmes in PH education, training, research and practice.
- (2) Development and implementation of collaborative multi-centric research projects.
- (3) Sharing/pooling of information, expertise and facilities.
- (4) Coordination of technical resources for contribution to national, regional and international work.
- (5) Sharing of experience in quality improvement of PHIs.
- (6) Development of systems for accreditation of PHIs.

- (7) Development and maintenance of an information system to serve a number of institutions in relevant areas.
- (8) Provision of guidance and support to member PHIs in collaboration with regional and international agencies.

The structure and functions of the Network

- The network should be set up at the national and regional levels.
- Criteria must be developed for inclusion of a PHI as a member of the network.
- To begin with, the secretariat, with dedicated personnel and resources, will function from WHO/SEARO; this arrangement could be reviewed later.
- The secretariat will have the advice and guidance of an expert advisory committee with leading public health professionals from Member Countries.
- During the first phase of development, the advisory committee will meet periodically to provide policy and strategy guidance for the network and review progress of network plans and activities. The committee will also conduct periodical reviews of outcome and impact of the network's work. The committee will also regularly assess the secretariat's functioning critically.
- The network should have a clear policy and plans for its work, with well laid out short, medium and long-term plans and programmes to be implemented through time-bound activities.
- With the approval of the advisory committee, the secretariat will appropriately assign and coordinate ad-hoc activities / responsibilities among member PHIs.
- The work should start simultaneously at regional as well as at country levels.

The Developmental Road Map of the network

Building the technical strength of the network

- WHO should immediately develop criteria for PHIs for inclusion in the network, in consultation with country/region

- The PHIs will be identified and additional nodal PHI will be selected
- A Memorandum of Understanding (MoU) should be developed to formalize networking and membership.
- Local networks, at country and sub-national levels, should be created for fostering public health education, training, research and practice.
- The strengths and weakness will be identified, using SWOT analysis, for overall strengthening of the network.

Resources

- WHO will have to provide the seed money for funding the secretariat
- WHO may promote resources and facilitate resource mobilization from other funding agencies for the institutions.

The sustainability of the network will depend on designated and committed staff, an evolving vision and a strategic plan, developing capacity of second-line personnel in the SEAPHEIN, continued commitment of WHO and funding agencies for supporting SEAPHEIN for 5 to 10 years, and the development of a mechanism within the legal and administrative framework as applicable.

The Way Forward –Action Plan for 2004/2005

The consultation recommended the following activities for implementation by the responsible agencies/organizations and suggested the time-frame for completion of each activity:

For Countries

- (1) 'Promotion of public health as a discipline' should be included as an important agenda item in the policy meetings at national and state/provincial levels of the government. (2004/2005)
- (2) The countries should constitute national core groups to provide direction for activities at national level and facilitate cooperation and collaboration. (March 2004)

- (3) The various national core groups, with the assistance of Public Health Training Institutions and concerned professional councils, should review the Public Health component of existing curricula of Medical Nursing, and other professionals. *(by June 2005)*

For SEAPHEIN

- (1) The proposed South-East Asia Public Health Education Institutes' Network (SEAPHEIN) should be formally launched at the upcoming meeting being hosted by Mahidol University, Bangkok. *(April 2004)*
- (2) The SEAPHEIN should set up E-networking linkages with seed money provided by WHO. *(May 2004)*
- (3) The proposed network, with information from its member PHIs, should identify its resource requirements and should, with assistance from WHO/SEARO, establish linkages with agencies for funding its various activities – both at regional and country levels for resource mobilization. *(June 2004)*
- (4) The SEAPHEIN should develop curricula and prototype materials for training in PH skills (including epidemiology, risk assessment, nutrition/health programme management, health sector reforms, health financing and health management information system), and disseminate this among the PHIs in the member countries. *(by June 2004)*
- (5) Best practices in the Region relating to PH services, research, training and education should be documented and widely disseminated through the proposed SEAPHEIN. *(October 2004)*
- (6) The SEAPHEIN should coordinate a comprehensive review of capacity and the current status of the training, research and service activities along with the managerial structures and practices in various public health institutions in the Member countries. This activity, to be partnered by the national core groups, may be funded by WHO. *(December 2004)*
- (7) An inter-country meeting should be organized by the SEAPHEIN, with WHO's support to discuss the findings of this review and their application for promoting PH as a discipline. This should be followed by country-level meetings, organized by the identified

nodal Public Health Institute (in collaboration with the national core group the SEAPHEIN and WHO). *(February 2005)*

- (8) Curriculum for the Regional MPH Programme should be updated and a training of trainers programme for MPH should be conducted. These activities may be completed by the SEAPHEIN, with WHO's support. *(by February 2005)*
- (9) Thrust areas for public health research should be identified by the proposed network with the assistance of WHO/SEARO, public health training institutions and research councils, and proposals developed for multi-centric research studies (country and region-wise). *(by June/July 2005)*
- (10) The SEAPHEIN should plan/organize/coordinate faculty development programmes and exchange visits/ fellowships in various sub-specialties of public health for teachers in public health from institutions at national and sub-national levels. The target for the Biennium 2004-2005 is 200 teachers from various Member Countries. *(by December 2005)*

For WHO

- (1) Include 'Public Health as a discipline' should be as an important agenda item in upcoming regional meetings of the Health Ministers, Health Secretaries and Parliamentarians. Preparatory activities, including background documentation should be completed. *(by March 2004)*
- (2) Establish a secretariat at SEARO to facilitate public health institution networking and implement PH-related activities. It should also constitute an expert advisory group to guide the secretariat in its work. *(by March 2004)*
- (3) Finalize arrangements for operationalization of the proposed SEAPHEIN. *(by March/April 2004)*
- (4) Organize regional training programmes in public health on emerging subjects on the pattern of the First International Executive Programme in Public Health held in November 2002. WHO could facilitate the organization of at least three such programmes annually. *(2004 and 2005)*

- (5) Facilitate PHIs, participating in SEAPHEIN, to involve in various programme managers' meetings organized by the technical units of WHO/SEARO. (2004 and 2005)
- (6) Arrange for funding towards successful performance of the activities in the proposed action plan. The consultation estimated the funding requirements for these activities at US\$ 250,000. (2004 and 2005)

Annex 1

PROGRAMME

Monday, 8 December 2003

0930 – 1000 Registration

1000 – 1030 **Inaugural Session**

- Inaugural Address – *Dr Uton Muchtar Rafei*, Regional Director, WHO South-East Asia Region
- Objectives of the Meeting – *Dr Monir Islam*, Director, FCH, WHO/SEARO
- Introduction of Participants – *Dr P.T. Jayawickramarajah*, Coordinator, SHS, WHO/SEARO
- Nomination of Chairperson, Co-Chairperson and Rapporteur
- Administrative Announcements – *Dr P.T. Jayawickramarajah*
- Group Photograph

1100 – 1230 **Presentations**

- **Review of Progress after Calcutta Declaration** – *Dr Palitha Abeykoon*, WHO Temporary Adviser
Discussions
- **Career Development in Public Health** – *Dr S.D. Gupta*, Director, Indian Institute of Health Management and Research, Jaipur, India
Discussions

1330 – 1500 • **Educational Reforms in Public Health** – *Dr P.T. Jayawickramarajah*, Coordinator/SHS, WHO/SEARO
Discussions

- **Challenges of Strengthening of Health System through Primary Health Care Approach** - *Dr Tej Walia*, HSD, WHO/SEARO
Discussions

1530 – 1630 • **Millennium Development Goals (MDG)** - *Dr Than Sein*, Director/EIP, WHO/SEARO

Discussions

Tuesday, 9 December 2003

- 0900 – 1030 Synthesis of the Discussions on the previous day
Theme 1 – Challenges, Opportunities and Constraints for Improving Public Health as a Discipline
- **Constraints, Opportunities for Improving Public Health in Practice** - *Dr Ahmad Al-Kabir*, Country Director, UFHP, Dhaka
 - **Public Health in Conflict Situation** – *Dr S. Kumaravetpillai*, Director, North-East Province, Trincomalee, Sri Lanka
- 1100 – 1200 Group Work on Identification of Constraints and Recommendations for improving Public Health as a Discipline in countries
- 1200 – 1230 Report to Plenary
- 1330 – 1500 **Theme 2 – Health Systems Research**
Research in Public Health – *Dr B.A. Jayaweera*, WHO Temporary Adviser
Discussions
Health Research Systems in Strengthening Public Health – *Dr Adik Wibowo*, RPC, WHO/SEARO
Discussions
- 1530 – 1700 Group Work

Wednesday, 10 December 2003

- 0900 – 1000 Synthesis of discussions on the previous day and report of the Group Work to the plenary
- 1000 - 1030 **Theme 3 – Structure and Operationalization of Networking of PHIs in the Region**
- **Experience of Networking in Public Health** – *Dr Chalermchai Chaikittiporn*, Mahidol University, Thailand
Discussions
 - **Possible Models for Networking** – *Dr Monir Islam*, Director, FCH, WHO/SEARO
Discussions
- 1100 – 1130
- 1130 – 1230 Group Work
- 1330 – 1500 Group Work continued and report to Plenary

1530 – 1630 Panel Discussions

- **Role of Public Health in Disease Control Programme**
Dr Sulochana Abraham, CMC Vellore
Dr Mahmudur Rahman, Director, NIPSOM, Dhaka
Dr J.P. Narain, Coordinator, HIV/AIDS & TB, WHO/SEARO
Mr Terrence Thompson, WSH, WHO/SEARO
Dr J. Leowski, NCS, WHO/SEARO

Thursday, 11 December 2003

0900 – 1030 Synthesis of the discussions on the previous day

1100 – 1200 Conclusion and Recommendations

1200 – 1230 Closing Session
Remarks by the Regional Director-Nominee
Remarks by the Regional Director

Annex 2

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Annex 3

INAUGURAL ADDRESS BY THE REGIONAL DIRECTOR

Dr Samlee, Regional Director-Nominee, Distinguished Participants, Ladies and Gentlemen,

It gives me great pleasure to welcome you all to the Informal Consultation on Future Directions in Public Health - Calcutta Declaration and Beyond.

At the outset, I would like to consider the context in which we are meeting today. I am certain that most of you are aware of the "Calcutta Declaration" which was the outcome of a landmark conference held in Calcutta in November 1999. Public health experts of international repute were present and about 20 technical papers were presented and discussed at the Conference. In addition to our own report, the "Journal of Health and Population in Developing Countries" published from the USA, devoted a special issue to this Conference.

Technical units in the WHO Regional Office have actively pursued the four elements of the Calcutta Declaration. In addition, two regional conferences were held to discuss "Accreditation Guidelines for Public Health Education and Training Institutions" and "Networking of Public Health Institutions".

Public health education, training and research have been receiving increased attention in Member Countries. Some countries have adopted or adapted the regional guidelines on accreditation. Others are promoting the development of guidelines and standards for public health education.

Public health is increasingly recognized as a discipline and an essential requirement. India, Indonesia, Nepal, Myanmar and Thailand have public health educational programmes at postgraduate levels catering to all health and related professions.

Nepal and Thailand have initiated networking of public health institutions at their respective national levels. Mahidol University in Thailand, which was identified as a nodal point, has planned to advance regional networking in public health. The first meeting on Networking of Public Health Institutions in the Region is scheduled for April 2004. Technical units in the Regional Office are also in the process of developing a regional web-page of academic and research institutes for the purpose of information and faculty exchange.

Towards providing essential knowledge in non-traditional subjects of contemporary relevance and promoting continuous professional development, the Regional Office assisted in organizing an executive programme in public health for public health practitioners in Bandung, Indonesia. Experts and teachers from Member Countries were also invited to participate in this programme.

Public Health Education and Medical Education, even though having some similarities, are not really the same in terms of direction and emphasis. Public health education deals primarily with the community and population whereas medical education deals with institutions and individuals.

Ladies and gentlemen, having discussed the context of this informal consultation, I would like to focus on some of the challenges in public health today.

The ministries of health of countries in the Region need to be strengthened in providing equitable access, removing imbalances in service provision and providing affordable and quality services.

Political conflicts, poverty and diseases continue to imperil health security at the regional and global levels. Some political decisions do not seriously take technical issues into consideration. Capacities of most ministries and departments of health need to be strengthened to meet the challenges of epidemiological and demographic transitions. This is partly due to the insufficient number of well-trained personnel in public health. Regulating an expanding private sector to include a public health orientation, and controlling out-of-pocket expenses for health care for the middle class and the poor, have become more important. Existing epidemiological surveillance systems and the capacity of public health laboratories need to be strengthened to tackle emerging epidemics and new diseases such as SARS.

With the global focus on **3 by 5** to contain HIV/AIDS, there is an urgent need to further strengthen public health infrastructure and development of human resources. Activities in training institutions need to be reviewed to enhance their knowledge and skills across the full array of public health needs. There is also a need to generate greater demand for public health training.

There is evidence that most of our global trade rules so far have disproportionately benefited richer nations, often at the expense of the poor. With our efforts to familiarize Member States about global trade agreements, there are signs that ministries of health and trade now understand the gravity of the situation and many countries have commissioned studies to assess the effects of globalization. The challenge today is for governments to best utilize regulations in favour of their national interests.

Our Director-General, Dr LEE Jong-wook, in his opening address at the Fifty-sixth World Health Assembly, emphasized the need for country-focused initiatives. In this respect, integrating primary health care with public health is an important consideration. In our scientific working group meeting held in Colombo in June this year, all Member Countries agreed to develop or strengthen family medicine as an essential discipline. Now, in this informal consultation, you may discuss different ways and means of coordinating primary health care and public health activities to strengthen the health systems in Member Countries.

In the past few years, our global work in public health has gone beyond preventive and promotive activities to emphasize the measurement of health status of populations and evaluation of investment in service provision. We have also introduced the concept of stewardship which requires vision, intelligence and influence, primarily by the policy-makers in ministries of health.

In your deliberations on future directions for public health beyond the Calcutta Declaration, I would urge you to consider the following:

- Refinement and use of instruments and tools developed by WHO
- Millennium Development Goals adopted by the United Nations
- Shifting focus of public health programmes to priorities as identified by the Commission of Macroeconomics and Health
- Development of appropriate human resources for health
- Collaboration between primary health care physicians and public-health practitioners
- Strengthening institutional capacity to carry out essential public health functions
- Supporting decentralization through redefining the roles of central, regional, provincial and district level health services
- Supporting social protection in health through social insurance and
- Facilitating the research agenda for public health and health systems development.

I am confident that you will have fruitful discussions, which will lead to the achievement of the objectives of this consultation.

I wish you all success in your deliberations and a pleasant and enjoyable stay in New Delhi.

Thank you.

Annex 4

REMARKS BY DR SAMLEE PLIANBANGCHANG, REGIONAL DIRECTOR-NOMINEE

Mr Chairman,

Thank you for giving me the floor.

The purpose of the Regional Conference at Calcutta in 1999 was to provide a platform for reviewing, in-depth, the situation regarding public health education and practice in WHO's South-East Asia Region, with the view to identifying means and ways to improve the situation. The Calcutta Declaration was the main output of the conference.

This regional consultation is another step to move forward in the strengthening and development of public health education and practice in the Region.

We have heard during the course of our deliberations the diverse views, perceptions and understanding on what is to be carried out together for better health of all people in our Region. Many good recommendations were made. WHO will certainly spare no efforts in providing necessary support for implementing them. However, in light of the limited resources in WHO, such support will have to be in phases with a careful prioritization of the issues.

The diversity of our views, perceptions and understanding as expressed at this consultation is not unusual. We do not come from the same school, and therefore cannot have the same views. However, to move forward together in the most efficient and effective manner, there is need to find common ground.

Mr Chairman,

Medicine and public health are not the same. While these are different, certainly there is a big overlapping area. In light of a dynamic change in the health area today, this difference will increasingly be seen. Medicine and public health are the two pillars supporting each other.

Medicine deals primarily with care of individuals in institutional settings. This care may be curative, promotive, preventive or rehabilitative.

On the other hand, public health denotes health of the public, community, population or group of population. Public health functions are primarily in the areas of health promotion and protection, disease prevention and control through cutting the transmission of disease agents and avoiding health risks.

Disease in public health is defined ecologically as a failure in the interaction between host, agent and environment, whereby environment is defined in the broadest sense to include not only the physical, but also psychosocial, cultural, political and economic factors.

Therefore, we need multidisciplinary and multisectoral actions to achieve public health goals, through the development and implementation of public health programmes, such as health education, nutrition, water and sanitation, malaria control, tuberculosis control, prevention of drug addiction and mental health, for example.

Tools used in public health are different from those used in medicine. Certainly, many tools are used together.

With these differences, thus, public health education cannot be seen as being the same as medical education, even though they very much relate to and support each other.

To better understand public health, we should know its history. But, it is unfortunate, that in most cases, the history of public health is not adequately taught, or not taught at all in medical schools or in any other health schools. At the same time the history of medicine is a standard chapter in the medical curriculum.

To achieve tangible results in measurable terms during the next few years in our attempt to strengthen public health education and practice in our Region, we need clarity in the principle and concept of public health, and we need to have a clear focus in our work. We may not be able to afford to work with vagueness any longer.

I also have the same belief as the Chairman that the principles and concept of public health as defined by its founders are still relevant to today's

health issues. But, what we now need is to reorient and reform the process of application of these principles and concept. This is especially so in light of the global changes we are witnessing today.

To strengthen public health in our Region, many things need to be done. However, the most important work that needs our urgent attention is human resource development for public health. Therefore, let us go in a big way without delay in the area of public health education which will be one of my overriding priorities when I assume the office from the 1st of March next year.

Mr Chairman,

I would like to see that we have our own framework for public health education in South-East Asia Region in light of our own specific regional situation; the framework that will be relevant for use by our Member Countries in their development of public health education programmes to suit their needs and requirements in the development of human resources for public health in their respective countries.

After assuming office, I will form a high-level professional task force to work out such a framework. Help from all of us here will also be needed in pursuing this exercise. A specially dedicated group at the Regional Office will be established to provide secretariat support to the task force.

Mr Chairman,

WHO has already put a lot of efforts in promoting and supporting the development of medical education in Member Countries. We will continue such promotion and support to ensure quality medical care services.

Annex 5

REGIONAL DIRECTOR'S CLOSING REMARKS

Mr Chairman, Distinguished Participants, Ladies and Gentlemen,

- First of all I would like to thank all of you for your active participation and valuable inputs.
- You will notice that the Calcutta Declaration was a very significant event which facilitated the promotion of public health in the Region.
- This consultation discussed the future directions of public health following the Calcutta Declaration. I am happy that a number of activities and recommendations have emerged out of this consultation on areas such as operationalization of networking of public health institutions in the Region, research in the field of public health and improving public health as a discipline in the countries of the Region. We will consider these recommendations seriously for implementation in the Region.
- I would also like to mention that the short courses for public health executives conducted at the University of Padjadjaran, are very important milestones towards a Regional MPH Programme.
- We are hoping to expand the short courses we had at Bandung and bring in expertise from the regional institutions to conduct similar courses.
- I wish to thank particularly, the Chulalongkorn University, Mahidol University, CMC Vellore, IIHMR, Jaipur, NIPSOM and the University of Indonesia for their contributions to the development of this programme.
- I believe that networking of public health institutions will be one of the essential activities to strengthen our work in public health.
- Similarly, we need to strengthen our research programmes in public health. If we do this, undoubtedly all the countries will recognize public health as a crucially important discipline and a specialty. This will lead to development of effective and efficient health systems in the countries of our Region.

- Although some countries like Thailand and Indonesia have been progressing satisfactorily in this regard, we need to make sure that all the other countries follow this example. Therefore, the need of networking and partnerships becomes a necessity.
- I would also like to thank some of our former directors of WHO/SEARO for their valuable contributions based on their vast experience in this field. This meeting itself is a good example of networking, as most of the staff from the different departments of SEARO have also participated and contributed.
- I am happy that Dr Samlee has attended this meeting as the Regional Director-Nominee, which shows his interest. I am sure he will implement the recommendations of this consultation to the extent possible in the years to come.
- Finally, I would like to thank you again for your valuable contribution in achieving the objective of this consultation. I wish you all a safe journey back home.
- Thank you.

